APPLICATION TO
GERBER LIFE INSURANCE COMPANY
1311 Mamaroneck Avenue
WHITE PLAINS, NY 10605
FOR
AGGREGATE AND SPECIFIC EXCESS LOSS INSURANCE

Application is hereby made to the Gerber Life Insurance Company ("Company") for Excess Loss Insurance. This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

1. Full Legal Name of Applicant: Montana Association of Counties

2. Address: 2715 Skyway Drive
   City: Helena State: MT Zip Code: 59601

3. If employee benefit plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal name and addresses of such companies.
   None

4. Enter the full name of your Employee Benefit Plan(s) - (A copy of such Employee Benefit Plan(s) must be attached.)
   MACo Statement of Inmate Benefit Plan.

5. Name and address of Designated Third Party Administrator:
   Consociate Group, 111 East Decatur Street, Decatur, IL 62525

6. Effective Date:
   September 01, 2009

7. Estimated Initial Enrollment (will be used as the Number of Covered Units during the first Contract Month): Will be determined baased on the actual enrollment.

8. **GENERAL SCHEDULE OPTIONS:**

   (a) Disabled Persons [X] are [ ] are not covered.
   Retired Employees [ ] are [X] are not covered.

   (b) Aggregate Benefit [ ] Yes [X] No

   Aggregate Contract Basis: Employee Benefit Plan Expenses must be
   Incurred from N/A through N/A, and
   Paid from N/A through N/A
   Claims Incurred prior to the Contract Effective Date are limited to N/A

8. **GENERAL SCHEDULE OPTIONS:** (Continued)

Aggregate eligible expenses include:

[ ] Medical [ ] Prescription Drug Card
[ ] Dental Care [ ] Weekly (Disability) Income
[ ] Vision Care [ ] Other

Aggregate Monthly Factor per:

	Composite	Medical
		N/A
Aggregate Payable Percentage (excess of Deductible)		N/A
Maximum Eligible Claim Expense Per Covered Person:		N/A
Minimum Aggregate Deductible:		N/A
Maximum Aggregate Benefit (excess of Deductible):		N/A

(c) Monthly Aggregate Accommodation [ ] Yes [X] No

(d) Terminal Liability [ ] Yes [X] No

(e) Specific Benefit [X] Yes [ ] No

Specific Contract Basis: Employee Benefit Plan expenses must be
Incurred from 9/1/2009 through 8/31/2010, and
Paid from 9/1/2009 through 2/28/2011.

Claims Incurred prior to the Contract Effective Date are limited to: N/A

Specific Eligible Expense: Medical Only
Specific Deductible (per person): $10,000

Specific Payable Percentage (excess of Deductible): 100%
Maximum Specific Benefit (per person in excess of Specific Deductible): $240,000

9. **PREMIUMS:**

(a) Aggregate Premium
- Premium Per Month Per Unit: N/A
- Minimum Annual Aggregate Premium: N/A

Monthly Aggregate Accommodation
- Premium Per Month Per Unit: N/A
- Annual Premium in Advance: N/A

Terminal Liability
- Premium Per Month Per Unit: N/A
- Annual Premium in Advance: N/A

(b) Specific Premium

Premium Per Day Per Inmate: Composite $0.53

Minimum Monthly Specific Premium: See Special Risk Limitations on page 3.

10. **SPECIAL RISK LIMITATIONS:**

Contract will be based upon the current employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:
XXX

Specific:

The following Montana State Statutes regarding Inmate Medical Cost, as noted in the Statement of Inmate Medical Benefits, will apply to both the Inmate Benefit Plan and the Excess Loss Contact: #7-32-2224 Payment of medical cost be entities other than inmate. # 7-32-2245 Payment of confinement and medical cost by inmate.

After the first policy has been in effect for six months, the participation level will be reviewed and the rate will be adjusted in accordance with the participation level at the end of the specified window of time.

Disabled person will be covered if eligible under the terms of the Statement of Inmate Medical Benefits.

Coverage for mental and nervous disorders, HIV Positive, substance abuse and maternity coverage are excluded unless otherwise elected.

It is hereby understood and agreed that all references to Employee Benefit Plan be recognized as the Statement of Inmate Medical Benefits with the Application to Gerber Life Insurance Company and within the Policy Providing Excess Loss Insurance.

Coverage for outpatient surgery and inpatient confinement will be covered as defined in the Statement of Inmate Medical Benefits.

Excess Loss Policy is subject to carrier approval upon submission of the Articles of Incorporation and audited Financial Statements.

The "Minimum Monthly Specific Premium" is to be determined based on the actual county participation.

Initial premium will be paid on or before the effective date for new counties participating under the Montana Association of Counties. Subsequent premiums are due 30 days following the last day of the month in order that an actual average enrollment count may be reconciled multiplied the number of days for that particular month.

Paragraph 11b in the Application to Gerber Life Insurance Company does not apply.

The "Unified Reimbursement" and "Unified Maximum" provisions are herby agreed to as shown in the Statement of Inmate Benefits.

Aggregate: None

11. **IT IS UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION, THAT:**

(a) All documentation requested by the Company must be submitted prior to any approval of

this Application and must be received by the Company within ninety (90) days of the requested Effective Date.

(b) If the Schedule shows disabled persons are not covered, no benefits will be paid under the Contract for expenses Incurred or Paid under the Employee Benefit Plan for a disabled person until:

(1) if an employee, he or she returns to active, full-time employment for at least one (1) full working day; or

(2) if a dependent or Continuation Beneficiary, he or she is able to perform the normal functions of a person of like sex and age.

(c) Issuance of the Contract is in reliance upon the information provided by the Applicant or its Agent. Should subsequent information become known which, if known prior to issuance of the Contract, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Insured.

11. **IT IS UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION, THAT:** (Continued)

(d) The Contract, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

(e) Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that Gerber Life Insurance Company disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

(f) If a Contract is issued and later rescinded, the sum of all benefits paid will be deducted from the sum of all premiums paid. If the result is positive, such amount will be paid by the Company to the Applicant. If the result is negative, such amount will be paid by the Applicant to the Company.

(g) The initial premium will be paid on or before the Effective Date, and subsequent premiums are due no later than the first day of each calendar month during the Contract Year.

(h) Applicant acknowledges that the Contract which is the subject of this Application is a reimbursement Contract. Applicant must first pay claims before submitting them for reimbursement.

(I) Oral Statements not expressly incorporated herein are not part of this Contract. Only the President or Executive Officer of the Company may make changes to the Contract Form or Addenda on behalf of the Company. All changes to this Contract must be in writing and attached to this Contract.

(j) NEITHER THIS APPLICATION NOR THE TERMS OF THIS APPLICATION MAY BE ALTERED.

In making this Application, the Applicant represents that, to the best of its knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Contract. Accordingly, this Application will be a part of the Contract if accepted by the Company or its authorized representative.

Dated at _____ this _____ day of 20____

Witness: _____ Applicant: Montana Association of Counties
Signature of Licensed Resident Agent
Tax ID:

By:_____
Officer/Partner

Title: _____

Licensed Resident Agent: _____

Address: _____
City: _____ State: Zip:
Social Security or Tax ID: _____

ACCEPTANCE

Accepted on behalf of the Company, this _____ day of 20____

By: _____

Title: _____

Contract No.: _____ Effective Date: 09/01/2009